Medicare

1993 Highlights

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Including Information on:

- **Advance Directives**
- **Participating Physicians & Suppliers**
- **Limits on Physicians' Charges**
- **Medigap Insurance**
- **Help for Low-Income Beneficiaries**
- **Coordinated Care Plans**

U.S. Department of Health and Human Services
Health Care Financing Administration

Medicare Benefits In Brief

The Medicare health insurance program provides comprehensive acute-care coverage for more than 33 million people age 65 and over. The program also serves about four million disabled people and nearly 200,000 people with chronic kidney disease who need dialysis or kidney transplants.

Medicare has two parts: Hospital Insurance (Part A) and Medical Insurance (Part B). Medicare-covered services may be provided through traditional fee-for-service arrangements, or by coordinated care plans, such as health maintenance organizations (HMOs).

This brochure is a handy summary of Medicare benefits and payments. If you would like further information, please refer to the Medicare Handbook, available from your local Social Security Office. Or call toll-free 1-800-638-6833.

1993 Medicare Costs

Part A Inpatient Hospital Stay
Deductible: $676
Coinsurance for Days 61-90: $169/day
After 90 days: $338/day
(for 60 lifetime reserve days)

Part A Skilled Nursing Facility Stay
First 20 Days: No Charge
Days 21-100: $84.50/day

Part B Medical Insurance
Deductible: $100
Part B Premium: $36.60 a month

Help for Low-Income Beneficiaries

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If you meet certain requirements, your state's Medicaid program may pay your share of health care costs under Medicare.

To qualify, your annual income must not exceed the national poverty guidelines (in 1993, $7,210 for one person, $9,670 for a couple). Also you cannot have resources such as bank accounts, stocks or bonds worth more than $5,000 ($6,000 for a couple). You CAN keep your house, a car and certain other assets.

State governments assist qualified Medicare beneficiaries by paying the monthly Medicare premiums and, in most cases, paying Medicare deductibles and coinsurance.

Financial help is also available for those with incomes from 101 to 110 percent of the poverty level. Those beneficiaries in this category are eligible ONLY for Medicaid payment of their Medicare Part B premium.

If you think you may qualify, contact your state or local welfare social services or public health agency and ask about the *Qualified Medicare Beneficiary Program*.

For the name of the agency to contact in your area, call 1-800-638-6833.

To report Medicare Fraud:
Contact Your Medicare Carrier
Or Call Toll-Free
1-800-638-6833

Hospital Insurance (Part A)

What's Covered?

Medicare covers items and services that are reasonable and necessary for the diagnosis and treatment of illness or injury. They include: inpatient hospital services, skilled nursing facility care for continued treatment or rehabilitation following hospitalization, home health care services, and hospice care for the terminally ill.

...And What's Not

Medicare does **NOT** cover convenience items such as telephones and televisions provided by hospitals or skilled nursing facilities, private rooms (unless medically necessary), or private duty nurses.

Benefit Periods

Medicare payments under Part A are based on **benefit periods**. A benefit period begins the day you are hospitalized, and ends when you have been out of a hospital or skilled nursing facility for 60 straight days. If you are readmitted within 60 days, you remain under the same benefit period and do not have to pay another deductible.

Medicare helps pay for hospital care for up to 90 days for each benefit period. After this, you can draw from a period of 60 lifetime "reserve days," but once you use a reserve day you can never get it back.

Nursing Home Coverage

Part A helps pay for care in a Medicare-participating skilled nursing facility, but only after a hospital stay of at least three days and only if the care is necessary because your condition requires daily skilled nursing or skilled rehabilitation services based on a doctor's orders.

Medicare does **NOT** pay for a stay in a nursing home or in a skilled nursing facility if the services provided are mainly personal care or custodial services, such as help in walking, getting in and out of bed, eating, dressing, bathing and taking medicine.

Advance Directives: Your Right to Decide

When you receive care from a Medicare-certified hospital, skilled nursing facility, hospice or home health care agency, or enroll in a HMO that contracts with Medicare, you must be asked if you have an **"advance directive"** — either a living will or a durable power of attorney for health care.

An advance directive is a legal paper you sign that states your choices for health care under certain medical conditions, such as a terminal illness, or names someone to make those choices for you.

You are NOT REQUIRED to have an advance directive. But, if you do, you can specify whether you want certain treatment if you are too sick to talk to a doctor, or that you don't want treatment under certain conditions you spell out in the document.

Laws governing living wills vary from state to state. Ask your health care provider about your state's rules.

MEDICARE PART A: HOSPITAL I

SERVICES	BENEFIT
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous hospital services and supplies.	First 60 days
	61st to 90th day
	60 Reserve Days**
	Beyond 150 days
SKILLED NURSING FACILITY* You must have been in a hospital for at least 3 days and enter a Medicare-approved facility within 30 days after hospital discharge.	First 20 days
	Additional 80 days
	Beyond 100 days
HOME HEALTH CARE Medically necessary skilled care.	Part-time or intermitte care for as long as you meet conditions
HOSPICE CARE Support services for the terminally ill.	If you elect the hospi option, as long as doctor certifies nee
BLOOD	Unlimited if medicall necessary.

* Inpatient hospital and skilled nursing facility cover
** The 60 reserve days may be used only once in a life

MEDICARE PART B: MEDICAL I

SERVICES	BENEFIT
MEDICAL EXPENSES Doctors' medical & surgical services, medical supplies, tests and more.	Medicare pays for medical services in or out of the hospital.
CLINICAL LABORATORY SERVICES	Unlimited if medically necessary.
HOME HEALTH CARE Medically necessary skilled care.	Part-time or intermittent skilled care as long as you meet conditions.
OUTPATIENT HOSPITAL TREATMENT	Unlimited if medically necessary.
BLOOD	Unlimited if medically necessary.

* For information on approved amounts, see pg. 9..
**To the extent the blood deductible is met under one not have to be met under the other part.

IS RANCE SERVICES FOR 1993

MEDICARE PAYS	YOU PAY
All but $676	$676
All but $169 a day	$169 a day
All but $338 a day	$338 a day
Nothing	All costs
100% of approved amount All but $84.50 a day Nothing	Nothing $84.50 a day All costs
100% of approved amount; 80% of approved amount for durable medical equipment.	Nothing for services; 20% of approved amount for durable medical equipment.
All but limited costs for outpatient drugs and inpatient respite care.	Limited cost sharing for outpatient drugs and inpatient respite care.
All but first 3 pints per calendar year.	For first 3 pints.

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S RANCE SERVICES FOR 1993

EDICARE PAYS	YOU PAY
0% f approved amount aft $100 deductible).	$100 deductible, plus 20% of approved amount (and limited charges above approved amount*).
00 of approved m nt.	Nothing for services.
00 of approved amount; 0% r durable medical qu ment.	Nothing for services; 20% of approved amount for durable medical equipment.
0% f approved amount aft $100 deductible).	$100 deductible, plus 20% of billed charges.
0% f approved amount aft $100 deductible and sta g with 4th pint).	For first 3 pints plus 20% of approved amount for additional pints (after $100 deductible).**

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Medicare Part A: Hospital Insurance Services for 1993

SERVICES	BENEFIT	MEDICARE PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous hospital services and supplies.	First 60 days	All but $676	$676
	61st to 90th day	All but $169 a day	$169 a day
	60 Reserve Days**	All but $338 a day	$338 a day
	Beyond 150 days	Nothing	All costs
SKILLED NURSING FACILITY* You must have been in a hospital for at least 3 days and enter a Medicare-approved facility within 30 days after hospital discharge.	First 20 days	100% of approved amount	Nothing
	Additional 80 days	All but $84.50 a day	$84.50 a day
	Beyond 100 days	Nothing	All costs
HOME HEALTH CARE Medically necessary skilled care.	Part-time or intermittent care for as long as you meet conditions.	100% of approved amount; 80% of approved amount for durable medical equipment.	Nothing for services; 20% of approved amount for durable medical equipment.
HOSPICE CARE Support services for the terminally ill.	If you elect the hospice option, as long as doctor certifies need.	All but limited costs for outpatient drugs and inpatient respite care.	Limited cost sharing for outpatient drugs and inpatient respite care.
BLOOD	Unlimited if medically necessary.	All but first 3 pints per calendar year.	For first 3 pints.

* Inpatient hospital and skilled nursing facility coverage is based on benefit periods. See pg. 4

** The 60 reserve days may be used only once in a lifetime. See pg. 4.

Medicare Part B: Medical Insurance Services for 1993

SERVICES	BENEFIT	MEDICARE PAYS	YOU PAY
MEDICAL EXPENSES Doctors' medical & surgical services, medical supplies, tests and more.	Medicare pays for medical services in or out of the hospital.	80% of approved amount (after $100 deductible).	$100 deductible, plus 20% of approved amount (and limited charges above approved amount*).
CLINICAL LABORATORY SERVICES	Unlimited if medically necessary.	100% of approved amount.	Nothing for services.
HOME HEALTH CARE Medically necessary skilled care.	Part-time or intermittent skilled care as long as you meet conditions.	100% of approved amount; 80% for durable medical equipment.	Nothing for services; 20% of approved amount for durable medical equipment.
OUTPATIENT HOSPITAL TREATMENT	Unlimited if medically necessary.	80% of approved amount (after $100 deductible).	$100 deductible, plus 20% of billed charges.
BLOOD	Unlimited if medically necessary.	80% of approved amount (after $100 deductible and starting with 4th pint).	For first 3 pints plus 20% of approved amount for additional pints (after $100 deductible).**

* For information on approved amounts, see pg. 9..

**To the extent the blood deductible is met under one part of Medicare during the calendar year, it does not have to be met under the other part.

Medical Insurance (Part B)

What's Covered...

Medicare Part B helps pay for medical and surgical services by physicians, clinical laboratory services, outpatient care, medical supplies, lab tests and a variety of other medical services and supplies.

...And What's Not

Part B DOES NOT cover: services unrelated to treatment of illness or injury; routine physical examinations; dental care or dentures; cosmetic surgery; most preventive care; routine foot care; hearing aids; eyeglasses or the exam to fit them. Most prescription drugs are NOT covered.

Pap Smears And Screenings for Breast Cancer

Medicare Part B helps pay for Pap smears once every three years to screen for cervical cancer, and once every other year for X-ray screenings for detecting breast cancer (mammography). The benefits are available more often for those at risk or when symptoms are present.

Health Centers That Offer Preventive Care

Certain local health centers will now provide Medicare beneficiaries with physical examinations, hearing and eye tests, flu vaccines and other preventive health care services. For the nearest one, call toll-free 1-800-638-6833.

Participating Physicians

Part B payments to physicians and most medical suppliers are based on a national fee schedule. The fee schedule amount *approved* for payment by Medicare can be less than the actual charge billed by the doctor or supplier.

For most Part B services that it covers, Medicare pays 80 percent of the approved amount. You are responsible for meeting the $100 Part B deductible, and for the remaining 20 percent of the a*pproved amount*.

If you receive services from a *participating physician or supplier*, you are responsible ONLY for your Medicare deductible and 20 percent coinsurance. That's because these doctors and suppliers have agreed to *accept assignment* on all Medicare claims, that is, they agree to accept the amount approved by Medicare as the total charge for covered services and supplies for all Medicare beneficiaries.

Call your local Medicare carrier for the name of participating doctors and suppliers in your area, or ask them for a free directory.

Limiting Charges

If your doctor is NOT Medicare-participating, you my be subject to charges beyond the Medicare-approved amount, but there is a limit.

In 1993 and thereafter, nonparticipating physicians may not charge more than 115 percent of the Medicare fee schedule.

Supplementing Your Medicare Coverage

Private Supplemental, or Medigap Insurance

Medicare provides basic protection against health care costs, but it does not pay all of your medical expenses, nor most long-term care expenses. You may wish to buy private health insurance, called **Medigap insurance,** to supplement your Medicare coverage.

Medigap policies are now standardized and easier to understand. Insurers are required to offer no more than 10 standardized plans, including a core benefit package and nine other different combinations of additional benefits that include the core package.

Medicare SELECT

Medicare SELECT is a new type of Medicare supplement health insurance permitted to be offered in some states.

The main difference between Medicare SELECT and traditional Medigap insurance is that a beneficiary with Medicare SELECT must agree to use the services of designated health care professionals, called "preferred providers." Premiums, however, are expected to be lower.

The states where Medicare SELECT can be offered are: Alabama, Arizona, California, Florida, Indiana, Kentucky, Minnesota, Missouri, North Dakota, Ohio, Texas, Washington, and Wisconsin.

Your Right to Medigap Coverage

No one age 65 or older who applies for a Medigap policy within six months after enrolling in Medicare Part B can be denied coverage because of a pre-existing medical condition. Such a condition is defined as a health problem for which medical advice or treatment was given or recommended by a doctor within six months before a policy becomes effective.

Coordinated Care

Medicare beneficiaries may have lower out-of-pocket costs if they choose to enroll in coordinated care plans that contract with Medicare, instead of receiving services through traditional fee-for-service arrangements.

Approximately 75 percent of Medicare beneficiaries live in areas served by such plans. Medicare enters prepayment contracts with health maintenance organizations (HMOs) and competitive medical plans (CMPs) to provide coordinated care to Medicare beneficiaries.

Medicare pays the plans a fixed amount each month to provide Medicare enrollees with all Medicare approved services. Some plans offer services beyond those covered by Medicare, such as certain preventive services.

For more information...

on Medigap or other aspects of Medicare, you can order Medicare's free *Guide to Health Insurance for People with Medicare.* To order, call toll free 1-800-638-6833.

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION
6325 Security Boulevard
Baltimore, Maryland 21207

Official Business,
Penalty For Private Use $300

Publication No. HCFA 02156
Revised 1993